#### AFFIDAVIT



| STATE OF ALABAMA )  |
|---|
| Barbar County   |
|   |
| 1, Dorothy Stanford, hereby certify and affirm that I                                 |
| am a Medical Records Clerk, at Ventress Correctional Facility;                        |
| that I am one of the custodians of medical records at this institution; that          |
| the attached documents are true, exact, and correct photocopies of certain            |
| medical records maintained here in the institution medical file of                    |
| one Willie Strickland, AIS#026537; and  |
| that I am over the age of twenty-one years and am competent to testify to             |
| the aforesaid documents and matters stated therein.                                   |
| I further certify and affirm that said documents are maintained in the                |
| usual and ordinary course of business at Ventress Correctional;                       |
| and that said documents (and the entries therein) were made at, or                    |
| reasonably near, the time that by, or from information transmitted by, a              |
| person with knowledge of such acts, events, and transactions referred to              |
| therein are said to have occurred   |
| This, I do hereby certify and affirm to on this the \(\frac{1 \lefta^{+h}}{}\) day of |
| October, 2005.  |
|   |
| Dorth Hayar   |
|   |
|   |
| SWORN TO AND SUBSCRIBED BEFORE ME THIS THE  |
|   |
| Day of October, 2005.   |

Notary Public

My Commission Expires

## PROBLEM LIST

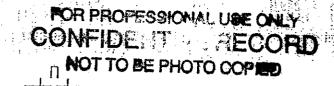
Mental Health Code SMI HARM (HIST NONE Date Code Assigned: 1/2/102)
(Changes in Mental Health Code should be identified on the Problem List)

| Date        | Chronic (Long-Term) Problems               | Date      | Health Care  |
|-------------|--|-----------|--------------|
| Identified  | Roman Numerals for Medical/Surgical        | Resolved  | Practitioner |
| — /— j      | Capital Letters for Psychiatric/Behavioral | 110001700 | Initial      |
| 123/3       | Anxady Duordin No.5-                       | 09-09-03  | <u> </u>     |
| 1/23/04     | 10 Coone Ahme                              | , , , , , | Jame MA.     |
| 4 30/on -   | Garning h lan-                             |           | 73/          |
| 8/21/03     | Headache Dirrines                          |           | 1-7          |
| 914103      | migrane Headache.                          |           | Cooley Clus. |
| 9-9-03      | HIST                                       | 94-83     | 1,44         |
| <u> </u>    |  |           | 1000         |
| 712-110     | - RIH                                      |           | TA TA        |
|             |  |           |              |
|             |  |           | -            |
|             |  |           |              |
|             |  | 3         |              |
| ·           |  |           | *            |
|             |  |           |              |
|             |  |           |              |
| <del></del> |  |           |              |
|             |  |           |              |
|             |  |           |              |
| <del></del> |  |           |              |
|             | POR PROPESSIONAL USE ONLY                  |           | *            |
| ·           | CONTENT AL TILOUTE                         |           |              |
|             | NOT TO BE PHOTO COPIED                     |           |              |
|             | NOTIODE                                    |           |              |

# FOR PROPESSIONAL USE CALLY CONFIDENTIAL PECOND

PRISON HEALTH SERVICES, INC. NOT TO BE PHOTO COPED
YEARLY HEALTH EVALUATION

| I      | HISTORY – (LPN or RN)   |                | YES   | NO   | COMMENT(S)  |
|--------|---|----------------|---|--|---|
|        | Weight Change (greater 15 lbs.) (Compare Weight Below) Persistent Cough Chest Pain Blood in Urine or Stool Difficult Urination Other Illnesses (Details) Smoke Dip or Chew ALLERGIES  ht 12.5 Temp 1.8 Height 10 "P   |                | . 1   | Blood P If greater than a Refer to M.D. is | Last weight at least 6 months ago    Car & 3 days     ressure   112/68     140/90, repeat in 1 hour.   fremains > 140/90. |
| II.    | TESTING – (LPN or RN)   |                | RESULT  | rs   |   |
|        | Tuberculin Skin Test (q yr)  Past Positive TB Skin Test (Chest x-ray if clinical symptoms) RPR (q 3 yrs) EKG (baseline at 35, over 45 q 3 yrs) Cholesterol (at 35 then q 5 yrs) Tetanus/Diptheria (q 10 yrs) (if done today) Optometry Exam (@ 50 if not alread Mammogram (females @ 40, q 2 yrs/other M.D. | s)<br>dy seen) | Read on Survey (                                  | Res<br>21-03 Res<br>12-03<br>NA<br>en 2001 | sults D mm  NA sults sults Due ZON  se — Lot # —  |
| III.   | PHYSICAL RESULTS – (RN, Mid<br>Class 1) 2 3 4 5<br>Heart<br>Lungs<br>Breast Exam<br>Rectal (yearly after 45)<br>with Hemoccult<br>Pelvic and PAP (q 1 yr)   | Restricti      | M.D.) ions No RRR Clear OKar Results Results Date | bilater<br>V NA                            | wilts —  Wate 4-8-05  |
| M.D. o | r Mid-Level Signature   |                | · · · · · · · · · · · · · · · · · · ·             | <b>X</b>                                   | Date 4 12 05  |
| INMATE | E NAME A  | IS#            | D.O.  | B.   | RACE/SEX  |
| Str    | ickland Brillie a   | 2 <i>265</i> 3 | 7   |  | w/n   |





PRISON HEALTH SERVICES, INC.

#### DEPARTMENT OF CORRECTIONS

#### NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

| Brenda Strickland                 | $\lambda \sim$ | other          |
|-----------------------------------|----------------|----------------|
| Name                              | Relations      | hip            |
| H165 Courty Roa<br>Street Address | d 299          | (334) 749-9393 |
|                                   |                | Phone Number   |
| Se Cusseta                        | Al             | 36852          |
| City                              | State          | Zip Code       |
| Ille Stuffa 220                   | 6537           | 4-08-05        |
| Inmate Signăture                  | AIS#           | SS# Date       |
| J. Huice, Com                     | <u>.</u>       | 4-8-05         |
| Witness                           | <del></del>    | Date           |

| <del></del> | <del></del>    | 1        |          |
|-------------|----------------|----------|----------|
| AIS#        | D:O.B.         | RACE/SEX | FACILITY |
|             |                |          |          |
| ŀ           |                | $\omega$ | ,        |
| ļ j         |                | · /      | 10       |
| 22/220      |                | /m       |          |
| KKPJS/      | '              | / / /    |          |
| ,           |                |          | - '      |
|             | AIS#<br>226537 |          | $\omega$ |

| IDENTIFICATION OF SPECIAL NEEDS                     |
|---|
| NAME (PLEASE PRINT) Trisklond Willie                |
| NAME (PLEASE PRINT)   LIST   WILLIAM   WILLIAM   MI |
| DATE OF BIRTH SS# 226537                            |
| Housing Recommendations:                            |
| General Population                                  |
| Medical Observation Unit                            |
| Lower Level\(\text{Lower Bunk}\)                    |
| Swinish Propositions                                |
| Suicide Precautions                                 |
| Special Watch (15 Minute Checks)                    |
| Isolation   |
| Initiate Universal Precautions                      |
|   |
| Individual found to be:                             |
| Frail/Elderly FOR PROPESSIONAL USE ONLY             |
| Physically HandigappedCONFIDENTIAL RECORD           |
| Developmentally Disabled NOT TO BE PHOTO COPED      |
| Drug/Alcohol Withdrawal                             |
| Special Mental Health Needs                         |
| Expressed Suicidal Ideation                         |
| History of Seizures                                 |
| Other   |
| Specify   |
| William not a lace                                  |
| Nurse Plus le 1 /25 /05                             |
|   |

Original/Classification

| NAME (PLEASE P                          | RINTO STRUM         | land Willie        |                                     |
|---|---------------------|--------------------|-------------------------------------|
| (= === ================================ | LAST                | FIRST              | MI                                  |
| DATE OF BIRTH                           |                     | SS#                | <del> </del>                        |
| Housing Recomme                         | ndations:           | <u> </u>           | all on Mon.<br>a gan for<br>with mo |
|   | General Pop         | pulation // //     | CV or provide                       |
|   | Medical Obser       | vation Unit /o/14  | a gum for                           |
|   | Lower Level/L       | ower Bunk          |                                     |
|   | Suicide Pred        | cautions           | With                                |
|   | Special Watch (15 N | // //inute Checks) |                                     |
|   | Isolati             | on                 |                                     |
|   | Initiate Universa   | l Precautions      |                                     |
|   |                     |                    |                                     |
| Individual found to                     | be:                 |                    | POPESSIONAL USE ONLY                |
|   | Frail/Eld           | ter l v            | DENTIAL RECORL                      |
|   | Physically Ha       | MUI                | TO BE PHOTO COPIED                  |
|   | Developmental:      |                    |                                     |
|   | Drug/Alcohol V      |                    |                                     |
|   |                     | Health Needs       |                                     |
|   | Expressed Suici     | dal Ideation       |                                     |
|   | History of S        | Seizures           |                                     |
|   | Othe                | ľ                  |                                     |
|   | Specify             |                    |                                     |
|   | \ \ \ \ \           |                    |                                     |
| Nurse /                                 | Jul 1/2, 1          | M Date <u>6/18</u> | 0/04                                |
| 1 1 1 1 1 22                            | 4 16                |                    |                                     |

Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit



#### **DEPARTMENT OF CORRECTIONS**

#### NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

| Brenda Stuckland | mach         | Rec      | ,         |         |
|------------------|--------------|----------|-----------|---------|
| Name             | Relationship |          |           |         |
| 4165 CTy Rd. 299 | _            | 334-749  | -939      | 3       |
| Street Address   |              | Pho      | ne Number |         |
| Cusuta           | al c         |          | 6852      |         |
| City ( ) (       | State        |          | Zip Code  |         |
| Wille Stuckland  | 226537       |          |           | 3/23/04 |
| Inmate Signature | Doc#         | S.S.#    | Date      | . ,     |
| monequel /       |              | <u> </u> | 3-23      | -04     |
| Witness          |              |          | Date      |         |

POR PROPESSIONAL USE ONLY CONFIDENTIAL RECORD NOT TO BE PHOTO COPIED

| , |  |                                     |          |          |
|---|--|-------------------------------------|----------|----------|
| 1 | INMATE NAME (LAST, FIRST, MIDDLE)              | DOC# DOB                            | RACE/SEX | FAC.     |
|   | Strickland Willi                               | 226537                              | wn       | VEF      |
| • | PHS-MD-70003 (White - Medical Record, Yellow - | Active File, Pink - Control Center) | <u> </u> | <u> </u> |

(White - Medical Record, Yellow - Active File, Pink - Control Center)

| Do you now or have     | you eve  | - <i>LA</i> L∠<br>er had |   | <u>653</u>  | <u>~ / </u>                                  | 98.8 1   | 1016        | 0            | 68                                      | 20          |
|------------------------|--|--------------------------|---|-------------|--|--|-------------|--------------|---|-------------|
| Problems               | Y  |                          |   | Y           | N  |  |             | N            |   | <u> </u>    |
| Head Trauma            |  | /                        | Kidney Stones/Disease                                   | ĺ           |  | Screening Observa  | tion.       |              | Check items belo                        | w & initial |
|                        |  |                          | 1   |             |  | / General Movement Deforming                                   |             |              | Clostiff<br>@ X's                       | meck        |
| Loss of Consciousness  | -  | <u>'</u>                 | Bladder/Kidney Infection                                |             | 1  | Biteeding  |             | が自           | @ X's                                   |             |
| Severe Headaches       |  | V                        | Alcoholism  |             | V  | Habitus, Hygiene Neuro Mental Status, Infox                    |             | 2            |   |             |
| Vertigo/Dizziness      | <u> </u>   | 1                        | Drug Abuse  | v           | 1  | Withdrawal, Tremors  |             | N            |   |             |
| Vision Problems        | <u> √</u>  | 1                        | Tobacco Use   | D           | <u> </u>                                     | Neuro-deficits   |             | BL           |   |             |
| Hearing Problems       |  |                          | Psychiatric Hx  |             | 0  | Skin Injury, Bruises, Trau<br>Jaundice                         | Tret        |              | Holes the                               | ough        |
| Dental Prob / Dentures |  |                          | Suicidal  |             | V  | Diaphoretic, Rash<br>Lesions, Infestations                     |             |              | Holes the                               | pples       |
| Seizures               |  | V                        | Communicable/Co   | ntagious    | 1  | Needle Marks Color, Turgor                                     |             | R            |   | f ¥         |
| Strokes                |  | /                        | Tuberculosis  |             | /  | Head Normocephalic   |             |              |   |             |
| Nervous Disorders      |  | V                        | HIVI AIDS   |             | 1  | Hair, Scalp  | i           | PL.          |   |             |
| DT's                   |  |                          | Hepatitis-Type  |             |  | Eyes Glasses/Vision<br>Pupils                                  |             |              |   |             |
| Heart Condition        |  |                          | Gonorrhea   |             | 1/   | Sciena, Conjunctiva  |             | <u>1</u> 1   |   | İ           |
| Angina/Heart Attack    |  | V                        | Syphitis  | 1           | 1  | Ears Appearance IV   | Brown       | 划            | Co decreos                              | e hear      |
| High B.P.              |  |                          | Lice; Crabs; Scabies                                    |             | 1  | Nose Epistaxsis, Sinuses                                       |             | 可以           |   |             |
| Anemia/Blood           | †  |                          | OB/ GYN   |             |  | Throat Teeth, Gums, Denture                                    | s (         |              | Degne O 1                               | ,,\$1       |
|                        |  | 7                        | LMR Date:   |             |  | Mouth Tongue, Tonsits<br>Arreny                                |             | ا ر<br>د     | Decayed f<br>white pato                 | NO          |
| ung Condition          |  |                          |   |             |  | Neck C Spine, Mobility   |             | ~            | male                                    | nein        |
| Asthma ·               | +  |                          | Duration:   | 4-1         |  | Veins, Carotids<br>Thyroid, Lymph Nodes                        | 6           |              |   |             |
| Bronchitis             | $\dagger \dagger$                                |                          | LMP Normal:   | 1           |  | Chest Config. Ausc. J Resp.                                    |             | $\exists$    | Hales Hro                               | uch         |
| Emphysenta             | 1-1  | <del>.</del>             | Regularity:   | 1           | N  | Cough/ Sputum  |             | ין נ<br>וונא | Holes thro<br>roth nipp                 | eles        |
| neumonia               |  | 7                        | Gravida/Para/   | 1           |  | (Breasts) Masses Heart Ausc Rate, Rhythm                       | I I         | 1            | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |             |
| Xabetes                | -  | 7                        | AB/Miscarriage:   | 1 1         | $\overline{}$                                | Murmurs, Ectopy  Abdomen Bowel Sounds                          |             |              |   |             |
| lay Feverl Allergies   |  |                          | Contraception:  | Υ           | N  | Pelp, G/R/T, Hemia GU Flank Tenderness                         |             |              | , <u>-</u>                              | :           |
| astritis               | +-   | 7                        | Describe:   |             |  | Bladder Tendemess /Distention                                  | E           |              |   |             |
| loars                  | <del>                                     </del> | $\mathcal{X}$            | LAB Tests- Dates  | N           | Ab   | Back ROM, Spasm, Injury  |             |              |   |             |
| leeding                | <del>                                     </del> | $\neg \nu$               | RPR 1-21-03   | 11          | <u>,                                    </u> | Extrem Edema, Pulse  | 1/*         |              |   |             |
| all Bladder/Pancreas   | <del>                                     </del> | 4                        | PPD- Date given: 3-23                                   | 4.          |  | Cyanosis-ROM, Injury<br>Genitals Injuries/Lesions              | P           | 4            |   |             |
| iver Problems          |  | 1                        | REALEA RF-  | <del></del> |  |  | 12          | 1            | lenied-po                               | Tuewte      |
| rthritis               | <del>  </del>                                    | 4                        | Date read 325   | <u>04</u>   | _  | Pelvic/Pap Deferred  |             |              | A COL                                   |             |
| oint Muscle Problem    |  | 4.                       | Results in mm.:<br>Deferred/Follow-up:>                 | ·<br>———    | _  | Rectal/Gulac Deferred  |             |              | ADE SSOR                                |             |
| ack/Neck Problem       | IЙ   |                          | Dental  |             | <b> </b>                                     | (Î)  | 103         |              | Opp VIIA                                | 2 TA        |
| xmments:               | :  | I                        |   |             | <u>l</u>                                     |  | , prej      |              | 707                                     |             |
| acement: GGeneral      | Popula<br>D4De                                   | tion (                   | ( ) Emergency Dept. ( ) !<br>( ) Mental Health ( ) Othe | solation    | ( ) Me                                       | dical Observation ( ) Other:_<br>then: ( ) immediately ( ) Nex | t Sick Call |              | TO BE PROT                              | ~ OCH       |
| A o A                  | )  |                          | 1 miles   |             | ••   | MANO MO  | <del></del> | //>          | -<br>1114                               |             |
| xneeuu.                | <del></del>                                      | <i>۱۷</i>                | 3/0 4 /0 41<br>Data/Sirr                                |             |  | Evaluator's Signatured Title                                   |             | 15           | Date/Time                               |             |

| NAME (PLEASE PRINT) Stickland Wille   |
|---|
| LAST FIRST MI   |
| DATE OF BIRTH SS# 226537  |
| General Population  |
| Isolation   |
| Initiate Universal Precautions  |
| Individual found to be:   |
| Physically Handicapped CONFIDENTIAL RECORD  Developmentally Disabled NOT TO BE PHOTO COPED  Drug/Alcohol Withdrawal Special Mental Health Needs Expressed Suicidal Ideation History of Seizures Other Other |
| SpecifyWillu Str Wan  |
| Specify   |

Original/Classification

| NAME (PLEASE PRINT)     | Strickland,   | <u>II) ill</u><br>FIRST | <u>MI</u>   |
|-------------------------|---|-------------------------|---|
| DATE OF BIRTH           |   | ss#_22                  | 10537   |
| Housing Recommendatio   | ns:   |                         | _   |
|                         | General Population  | _ BB                    | X6 mos.<br>21.05 -7<br>21.06)                       |
|                         | Medical Observation Unit_   | (7.7                    | 21.05 7   |
|                         | Lower Level/Lower Bunk  | X 1.                    | 21.06)  |
|                         | Suicide Precautions_  | - <del>-</del>          |   |
| Spo                     | ecial Watch (15 Minute Check  | ks)                     |   |
|                         | Isolation   |                         |   |
|                         | Initiate Universal Precautions  | S                       |   |
| Individual found to be: | Frail/Elderly Physically Handicapped Developmentally/Disabled_ Drug/Alcohol Withdrawal_ Special Mental Nealth Needs | e                       | Hernia truss<br>X le mos,<br>7-21-05 -><br>1-21-06) |
|                         | Expressed Suicidal Ideation   |                         | DENTIAL RECORD                                      |
|                         | History of Seizures   | _ NOT                   | TO BE PHOTO COPIED                                  |
| Spec                    |   |                         |   |
| Nuise All               | · ·   | Date 7.21               | 1.05  |

Willie Strklant

| NAME (PLEASE PRINT)       | Stickle                    | and We  | lhu# 226537           |
|---------------------------|----------------------------|---------|-----------------------|
| •                         | LAST                       | FIRST   | MI                    |
| DATE OF BIRTH             |                            | SS#     |                       |
| Housing Recommendation    | ns:                        | 4       |                       |
|                           | General Population_        | $\perp$ |                       |
|                           | Medical Observation U      | nit     |                       |
|                           | Lower Level/Lower Bu       | nkX_    |                       |
|                           | Suicide Precautions        |         |                       |
| Spe                       | cial Watch (15 Minute Cl   | hecks)  |                       |
|                           | Isolation                  |         |                       |
| I                         | Initiate Universal Precaut | ions    |                       |
| Individual found to be: Æ | 3BP 7/18/                  | 05-7    | 21/05                 |
|                           | Frail/Elderly              |         |                       |
|                           | Physically Handicappe      |         |                       |
|                           | Developmentally Disabl     | edFOR   | PROPESSIONAL USE ONLY |
|                           | Drug/Alcohol Withdraw      | al      | FIDENTIAL RECORD      |
|                           | Special Mental Health No   | eeds    | TO BE PHOTO COPIED    |
|                           | Expressed Suicidal Ideati  | on      |                       |
|                           | History of Seizures_       |         |                       |
|                           | Other                      | Pisk ta | myay                  |
| Specia                    |                            |         | 0 /                   |
| Nuise Dullo               | 100/S)                     | Date Z  | 18-05                 |
| 1/1/1/5                   | 10/1/                      | 11.527  |                       |



#### **DEPARTMENT OF CORRECTIONS**

#### RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

| ١,                 | U      | 1/1/10 57<br>(Print Name)  | rickland                  | <i>t</i>          | Z-J-<br>(Doc#)                | 05           |
|--------------------|--------|----------------------------|---------------------------|-------------------|-------------------------------|--------------|
| а                  | ckno   | wledge receipt of th       | ne following medical equ  | ipment or applia  | nce:                          |              |
| (                  | )      | Splint                     |                           |                   |                               |              |
| (                  | )      | Eyeglasses                 |                           |                   | FOR PROPESSION                | HAL USE ONLY |
| (                  | )      | Dentures                   |                           |                   | CONFIDENTIA                   | IL RECORD    |
| (                  | )      | Prothesis.                 | describe                  |                   | NOT TO BE PH                  | TO COPIED    |
| (                  | )      | Wheelchair                 |                           |                   |                               |              |
| (                  | )      | Cane                       |                           |                   |                               |              |
| (                  | )      | Crutches                   | $\wedge$                  | · 0               | //                            | 6. 1         |
| (                  | X)     | Other                      | describe draw             | unaf              | Hernia                        | MA           |
| 1:                 | ackno  | owledge that the ec        | quipment/appliance is fur | nctional for my u | se.                           |              |
| La                 | also a | acknowledge the ed         | quipment/appliance is in  | good working o    | ondition.                     |              |
| * \ \frac{\psi}{-} | 8      | Mi Strie<br>Mener<br>Mener | ekland<br>Rild p          | X-                | 3-2-05 (Date) $3-2-05$ (Date) |              |

DOC# DOB INMATE NAME (LAST, FIRST, MIDDLE)

PHS-MD-70005

(White - Medical File, Yellow - Security Property Officer)

| IDENTIFICATION OF SPECIAL NEEDS                    |
|--|
| 16 610 11/11/ 12/655                               |
| NAME (PLEASE PRINT) STAND FIRST MI                 |
| LAN  |
| DATE OF BIRTH SS#                                  |
|  |
| Housing Recommendations:                           |
| General Population                                 |
| Medical Observation Unit                           |
| Lower Level/Lower Bunk                             |
| Suicide Precautions                                |
| Special Watch (15 Minute Checks)                   |
| Isolation  |
| Initiate Universal Precautions Lan and Military    |
| you cope wire                                      |
| Individual found to be:                            |
| Individual found to be.                            |
| Frail/Elderly                                      |
| Physically Handicapped                             |
| Developmentally Disabled FOR PROFESSIONAL RECORD   |
|  |
| Special Mental Health Needs NOT TO BE PHOTO COPIED |
| Expressed Suicidal Ideation                        |
| History of Seizures                                |
| Other  |
|  |
| Specify  |
|  |
| Nurse Date J-10-03                                 |
| Willie Strickland 226537                           |

| NAME (PLEASE PRINT)     | Hrick/and                 | T VII         | MI MI   |
|-------------------------|---------------------------|---------------|---|
| DATE OF BIRTH           |                           | _ SS#         | 226537  |
| Housing Recommendation  | 18:                       |               |   |
|                         | General Population_       |               |   |
|                         | Medical Observation U     | nit           |   |
|                         | Lower Devel/Lower Bu      | nk            | Roffon Blank                                  |
|                         | Suicide Rrecautions       |               |   |
| Sne                     | ecial Watch (15 Minute C  |               | Profile X                                     |
| Орс                     | Isolation                 | , <del></del> |   |
|                         | /                         | -<br>tions    | Cays  |
|                         | Initiate Universal Precau | tions         | 11-24-04                                      |
| Individual found to be: |                           |               | Botton Bunk Profile X Codys 11-24-04 11-30-04 |
|                         | Frail/Elderly             | <del></del>   |   |
|                         | Physically Hand capp      | ed            |   |
|                         | Developmentally Disab     | oled          |   |
|                         | Drug/Alcohol Withdra      |               | Willer Streples                               |
|                         | Special Mental Health     | 1             | William                                       |
|                         | Expressed Suicidal Idea   | 1             |   |
|                         | History of Seizures       |               | FOR PROPESSIONAL USE CHLY                     |
|                         | Other                     |               | ONFIDENTIAL RECOR                             |
| Spec                    | cify                      |               | - MOLIOBELHOLOGO                              |
| Nuise Millimury         | <u></u>                   | Date          | 11-24-04                                      |

## FOR PROPESSIONAL USE ONLY CONFIDENTIAL RECORD 04 NOT TO BE PHOTO COPPED Warden Giles I am writing this letter because I am concerned about the medical condition of my son, Willie Strickland. He has a herrica and has been hurting for approx. 2 months. He has been times. to give him a Truss helping. He has been to a hennia does not go away by itself. He is in pain and Know what steps we to act him medical treatment will more than likely be surgery. 10 have tried numerous time reach you by phone regarding this haven't been able is a serious matten your immediate attention. you 4165 Co. Rd. 299 Cusseta, al. 36852. would appreciate a quier response you regarding this matter ncerely, Brenda

To: Warden Giles From: N. Burks Date: 6/8/04 Ref: Strickland, Willie

# FOR PROPESSIONAL USE ONLY CONFIDENTIAL RECORD MOT TO BE PHOTO COPIED

Inmate Strickland, Willie 226537 turned in a sick call request dated 5/5/04, complaining of "severe abdominal pain on right side". Was seen at sick call on 5/6/04 and referred to M. D. Appointment given for 5/7/04. Dr Rayapati's assessment, wants bottom bunk, abdominal non-tender. Bottom bunk profile denied.

On 5/14/04, Strickland put in another sick call request, complaining of "pain in right of stomach beside groin area". He was seen at sick call on 5/14. Appointment given to see M.D. on 5/17/04. Dr Rayapati's assessment, reducible non tenderness over pubic area no redness or swelling.

questionable prodroma hernia. Malingering for bottom bunk. Truss ordered.

On 6/3/04, I spoke to inmate per his request in reference to above complaints. I gave Strickland another appointment to see M.D. for further evaluation on 6/3/04. He was Diagnosed with right inguinal hernia, given a lay in profile.

I will speak with Dr Raypati this week in reference to referring Strickland to Dr Whyte for a surgical evaluation

N Burks, RN, H. S. A.

| IDENTIFICATION OF SPECIAL  NAME (PLEASE PRINT)  LAST  FIR  | Willie   |
|--|--|
| DATE OF BIRTHSS#   |  |
| Housing Recommendations:   |  |
| General Population  Medical Observation Unit  Lower Level/Lower Bunk  Suicide Precautions  Special Watch (15 Minute Checks)  Isolation  Initiate Universal Precautions | Lay in Profile<br>X6 months                                      |
| Individual found to be:  | _  |
| Drug/Alcohol/Withdrawal Special Mental Health Needs Expressed/Suicidal Ideation  History of Seizures  Other  | OR PROFESSIONAL USE ONLY ONFIDENTIAL RECORD MOTTO BE PHOTO COPED |
| Nurse Le Shell Lezarza   | 6/3/0/   |

GLF 1005

Original/Classification

Second Copy/Booking Staff

Third Copy/Medical Unit

| NAME (PLEASE PI     | RINTO STANI          | March Milli        |                  |
|---------------------|----------------------|--------------------|------------------|
|                     | LAST                 | FIRST              | MI               |
| DATE OF BIRTH       |                      | SS#                |                  |
| Housing Recommen    | dations:             | TO                 | HCU @            |
|                     | General Popu         | ulation \(\sigma\) | 2 1/2 /          |
|                     | Medical Observ       | ation Unit         | -011 9           |
|                     | Lower Level/Lo       | wer Bunk           | m                |
|                     | Suicide Preca        | nutions            | ap)              |
|                     | Special Watch (15 Mi |                    |                  |
|                     | Isolatio             |                    | H BURAS          |
|                     |                      |                    | ,,,,             |
|                     | Initiate Universal   | riecautions        |                  |
| Individual found to | be:                  |                    |                  |
|                     | Frail/Elde           | rly                |                  |
|                     | Physically Hand      | licappedFOR PROPE  | SSIONAL UNE ONLY |
|                     | Developmentally      | Disabled CONFIDE   | NTIAL RECOF      |
|                     | Drug/Alcohol W       | ithdrawalNOT TO 🕏  | EPHOTO OTOPISO   |
|                     | Special Mental He    | ealth Needs        |                  |
|                     | Expressed Suicida    | al Ideation        |                  |
|                     | History of Sei       | izures             |                  |
|                     | Other_               | <del></del>        |                  |
| ^                   | Specify              |                    |                  |
| Nurse / Bu          | MAN                  | Date 6/2/          | ,<br>34          |
| J. J. A             | / [/)                |                    |                  |

GLF 1005 Original/Classification

Second Conv/Booking Staff

Third Conv/Medical Unit

| NAME (PLEASE PRINT)     | Trickland                 | e Will      | (am)                                       |       |
|-------------------------|---------------------------|-------------|--|-------|
|                         | LAST                      | FIRST       | MI   |       |
| DATE OF BIRTH           |                           | SS#         |  |       |
| ·-                      |                           | AISE        | 226537                                     |       |
| Housing Recommendation  | ıs:                       |             |  |       |
|                         | General Population        | /           | 10 10                                      | )~; I |
|                         | Medical Observation U     |             | Iruss for k<br>X6 (six) Mo<br>5/17/04 - 11 | LH    |
|                         |                           | .1.         | X6 (Six) NO                                | nths  |
|                         | Lower Level/Lower Bu      | nk          | NO OR MAN                                  | 1 1   |
|                         | Suicide Precautions_      |             | 5/17/04 - 11                               | 17/04 |
| Spe                     | cial Watch (18 Minute Cl  | necks)      | 1 1 1                                      | , ,   |
|                         | solation                  |             |  |       |
| 1                       | nitiate Universal Precaut | ions        |  |       |
|                         | ,                         | .`          |  |       |
| Individual found to be: |                           | FORP        | Po==                                       |       |
| marriada rodna to be.   |                           | CONFI       | POPESSIONAL USE OF DENTIAL RECO            | Mi s  |
|                         | Frail/Elderly             | NOT:        | TO BE PLOT                                 | )RD   |
|                         | Physically Handicappe     | <u> </u>    | TO BE PHOTO COPER                          | )     |
|                         | Developmentally Diszbl    |             |  |       |
|                         | Drug/Alcohol Withdraw     | al          |  |       |
|                         | Special Mental Health No  | eeds        |  |       |
|                         | Expressed Saicidal Ideati | on          |  |       |
|                         | ~~. / . ~ · \             |             |  |       |
|                         | History of Seizures       | <del></del> |  |       |
|                         | Other                     |             |  |       |
| Speci                   | Other                     |             |  |       |
| Speci                   | Other                     |             | 11.  |       |
| Speci                   | Other                     | Date 5      | 117/04                                     |       |
| Specing Specing Nurse   | Other                     | Date_5      | 117/04                                     |       |
| Special Nurse Gonaso    | Other                     | Date 5      | 117/04                                     |       |

| NAME (PLEASE PRINT      |  | llie       |  |
|-------------------------|--|------------|--|
|                         | LAST                                   | FIRST      | MI   |
| DATE OF BIRTH           | *                                      | SS#        |  |
| <del>-</del>            | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | A15#2      | 26537  |
| Housing Recommendation  | ons:                                   |            | ·  |
|                         | General Population                     | Retu       | rn to Hell when Rt<br>area Starts to Fu<br>wrses Can Observe   |
|                         | Medical Observation Unit               | groin      | area Starts 40 m   |
|                         | Lower Level/Lower Bunk                 | - Sox      | wrses Can Observe  |
|                         | _                                      | cena       | grace here to  |
|                         | Suicide Presautions                    | – cha      | rt,  |
| Sp                      | pecial Watch (15 Minute Check          | ks)        |  |
|                         | Isolation                              |            |  |
|                         | Initiate Universal Precaution          | ξ          |  |
|                         |  |            |  |
| Individual found to be: |  | 800 n      | <b>-</b>   |
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|                         | Developmentally Disabled_              |            |  |
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|                         | Special Mental Health Needs            | s          |  |
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|                         | History of Seizures                    | <u> </u>   |  |
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| Spec                    | eify /                                 |            |  |
| 1, 0                    | ;                                      | <b>\</b> - | . 1  |
| Nuise Hohnso            | n MN                                   | Date 5     | 17/04  |
| Walle                   | u Suklas                               | 2265       | 87   |



#### **EMERGENCY**

| ADMISSION DATE TIME ORIGINATING FACILITY $5/6/9130$ , FM OSIR OPDL OSIGNATING FACILITY |   | □SICK CALL □EN                     | MERGENCY<br>NT     |
|--|---|------------------------------------|--------------------|
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| NATURE OF INJURY OR ILLNESS  | ABRASION /// CONTUSION # BURI                             | N XX FRACTURE Z LAC                | CERATION / SUTURES |
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| et fierts  |   |                                    | ) [                |
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| or Edema notel   |   |                                    |                    |
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| A A  |   | SIGNAL USE OF                      | WLY N              |
| 9- Motrin 600mg Po HOX 3kay  | CONFIDER  | STAL REC                           |                    |
| V  | NOT TO BE   | PHOTO COP®                         |                    |
| DIAGNOSIS  |   |                                    |                    |
| NSTRUCTIONS TO PATIENT LO NUEL CALL of De  | en anericals  | or if coa                          | (1477)             |
| Manual TIME RELEASE / TRANSFERRED  |   | ON ON DISCHARGE                    |                    |
| 5 10 04 9 37 AM  WASE'S SIGNATURE, DATE PHYSICIAN'S SIGNATURE                          | TO #DEC CONDITION  AMBULANCE #LSATISF  FAIR  DATE CONSULT | ACTORY POOR CRITICAL               | <u>L</u>           |
| LULIAGAM ON 5-1004 MINISTRATE NAME (LAST, FIRST, MIDDLE)                               | 1   |                                    | EAC                |
| Strickland Willie  | 1 16537   | B R/S                              | FAC UCF            |
| - Chilled Will's   | Q44001  |                                    | - 4                |



#### **RELEASE OF RESPONSIBILITY**

| Inmate's Name: Weller Still  |   |                     |
|--|---|---------------------|
|  | Social Security No: AIS# 2265   | 375                 |
| Date: 12-31-03   | Time: 8137  | AM.<br>P.M.         |
| This is to certify that I, Willie St   | Vickland (Print Inmate's Name)  | , currently in      |
| custody at the   | acility's Name)   | , am refusing to    |
| accept the following treatment/recommendations:  | Call on 12-31-03 (Specify in Detail)  |                     |
|  |   |                     |
| I acknowledge that I have been fully informed of and und involved in refusing them. I hereby release and agree to hold have      | parmiess the City/Coun Sala st Q to Sala  | ny air correctional |
| personnel, Prison Health Services, Inc and all medical personne action/refusal and I personally assume all responsibility for my | el from all responsibility of the property of |                     |
| Wille The Sty  | alleliaten B  |                     |
| - (Signature of Anmale)  | (Signature of Medical Person)   |                     |
| (Witness)  | (Witness)   |                     |

<sup>\*\*</sup>A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



#### **PHYSICIANS' ORDERS**

| NAME:                    | DIAGNOSIS (If Chg'd)                                      |
|--------------------------|---|
| D.O.B / /                |   |
| ALLERGIES:               |   |
| Use Last Date / /        | ☐ GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED            |
| NAME:                    | DIAGNOSIS (If Chg'd)                                      |
| D O.B., / /              |   |
| ALLERGIES:               |   |
|                          |   |
| Use Fourth Date / /      | ☐ GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED            |
| NAME:                    | DIAGNOSIS (If Chg'd)                                      |
|                          | FOR PROFESSIONAL USE ONLY                                 |
| D.O.B. / /               | CONFIDENTIAL RECORD                                       |
| ALLERGIES:               | NOT TO BE PHOTO COP 1880                                  |
|                          |   |
| Use Third Date / /       | ☐ GENERIC SUBSTITUTION IS NOT PERMITTED                   |
| NAME: Strickland Willie  |   |
| 22622,1                  | Mobin 200 mg TIpo BID X I month Paid                      |
| D.O.B. N. Maris          | Theavy lefting > 15 # X lomate                            |
| ALLERGIES: NKA           | 0 0 ) .   |
|                          |   |
| Use Second Date 8 135705 | ☐ GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED Mas across |
| NAME: STRICKLAND, WILLIE | DIAGNOSIS   |
| #22/537                  | BB Pref. 4 X Comant                                       |
| DOB!                     | cont nearing hernia turn                                  |
| ALLERGIES: NKP           | X Coma Puz  |
| Use First Date 12 105    | GENERIC SUBSTITUTION IS NOT PERMITTED DE ON ORNE          |
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|  | PHYSICIANS ORDERS                          |
|--|--|
| NAME: Strickland Willie,<br>#226537 -118/03                  | DIAGNOSIS (If Chg'd) Auf,                  |
| D.O.B., ALLERGIES: NKOA 5130K                                | GENERIC SUBSTITUTION S NOT PERMITTED       |
| NAME: Strikland, Willie # 226537                             | DIAGNOSIS (If Chg'd)  Trust - 6 600        |
| ALLERGIES: NKDA Allegent                                     | GENERIC SUBSTITUTION IS NOT PERMITTED      |
| NAME: Strickland, Willie # 226537 xolul                      |  |
| ALLERGIES: NKDA  Use Third  Date  Date                       | GENERIC SUBSTITUTION IS NOT PERMITTED      |
| NAME: Strikland, Willie # 226537  DOB. ALLERGIES: NKDA- WIZO | DIAGNOSIS (If Chg'd)  lay in profile 6 his |
| Use Second Date 6/3/64                                       | DIAGNOSIS RIA VON                          |
| DOB ALLERGIES: NKDA  Date 517, 04                            | GENERIC SUBSTITUTION IS NOT PERMITTED      |

| Date/Time                  | Inmate's Name: | Stricklan      | I Willie   | D.O.B.:      | 1 1  |
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|                            | nan            | 1155 AAOX3     | Ambilaku 5   | Delich       | nun4   |
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|                            |                |                |  |              |  |
|                            |                |                |  |              |  |
|                            | •              |                |  |              |  |



#### **PROGRESS NOTES**

| 1           | THOUSE NOTES  |                       |
|-------------|---|-----------------------|
| Date/Time   | Inmate's Name: Strichland, Willie 2                 | 76537 D.O.B.:         |
| 222-05/1037 | W+. 193 # BP110/10 P 76 R 18 -                      | 1 99.2 = 40 hernia    |
|             | pre-existing problem-                               | - Hostolyhin          |
| [0          | ) RIH - Ken Inall                                   |                       |
|             | rednable - carry CONF<br>111- Exaggerating NO       | POPESSIONAL USE ONLY  |
|             |   | TO BE PHOTO COPPED    |
|             | 4 RIH-  | UT is lessing forme   |
|             | nedsteble_  | device - 9 scrold     |
|             | ) may use Truss - unduly                            | Lupport.              |
| i           | //  |                       |
| 7.21.05/11  | 15 190#-99.8-110/58-80-18-                          | reg. bottom buck      |
|             | Nofile Charles                                      | Blastotesmi           |
|             | 3 ( Wm fr Cluss one o H4.<br>12 yrs dens n size ora | of (R) organol herria |
|             | MAD US) MAUKS                                       | Sweds                 |
|             | ABD Soft NT @ Lane                                  | ABD TROA              |
|             | OSwelling BS +x4 h                                  | ,                     |
| A           | 1 inguirel herma                                    |                       |
| P           | cont hervia truss & Coman                           | Tyss body             |
| 1/2         | BB Profile & Comer                                  |                       |
|             | Report any 7 size a NUID a                          | <u> </u>              |
| 0111 (5/85) |   | Hal cano              |
| , . , ,     | nplete Both Sides Before Using Another S 1          |                       |

| Date/Time | Inmate's Name: SHICKland, Wille 22653) D.O.B.:                           |
|-----------|--|
| 6/3/04    | W. 190 B/P 128/66 P74 R16 T98  |
| (5)       | Herpia   |
| 0         | Ren Frall RVH-   |
| 7         | Reducible - NT -   |
|           | has BBB Trus-  |
|           | Abd foff_NT  |
|           | No selall men  |
|           | NO PALPABLI MASSY FOR PROPESSIONAL USE ONLY  NL-05 - CONFIDENTIAL RECORD |
|           | OULU Exam NL. NOT TO BE PHOTO OUT BO                                     |
| - (A      | 1 · RIH · Small  |
|           | ) Lay in profile -   |
|           | D 1  |
| 4-04/1055 | W+193 Bp 109/14 P70 R18 T99.2 - % herria                                 |
| ,         | C. Hunter, LPN   |
|           | 90 Hernio CRIH-Smell-reducible   |
| 6)        | diagnosed 5/17/04 -  |
| a)        | an Standing a Smell RIH - palpable that disappears                       |
|           | ON Infine polition: NT - Benegio - they diagnosed                        |
|           | a month ago - Henrie Like - Jeans wormel Lige -                          |
|           | No fignish land di lation of (R) linguine f King                         |
|           | the rest of the grain for removedle -                                    |
|           | The letters from in us, to HSA and Warden notes                          |
| (A)       | - Small RTH  |
|           | on profile - Truss not at provided - 2 Shortage                          |
| (b)       | 1 It IM wants Lungery - I Swook will Som will                            |
|           | Corte anile a surgery Consult for approvale                              |
|           |  |
|           | Long   |
|           | U <sup>*</sup>   |



#### **PROGRESS NOTES**

| Date/Time   | Inmate's Name: Strikland, Willie #226537 D.O.B.:                          |
|-------------|---|
| 5-7-04/1030 | W+189.5 8/2109/60 P61 R16 T 986-90 @ abd. pain<br>x / week C. Hunter, LPN |
|             | X   week C. Hunter, LPN   |
|             | Want BBB  |
| 0           | Abd NT foff BS-NL.  |
|             |   |
|             | Normal Exam  MOR PROPESSIONAL USE ONLY                                    |
|             | denied 1883 CONFIDENTIAL RECORD   |
|             | NOT TO BE PHOTO COPED   |
|             |   |
| 5/11/04     | Pain Rt groin area  |
| 1035        | Pain Rt groin war<br>Wt 1910les P-76 R-18 T98,8 Pulse ox 98% Bp 122/60    |
| <u> </u>    |   |
|             | Johne Swilling Corner at 6 pm. In 27: area.                               |
|             | NOW Some Reproducible lender new any                                      |
|             | public pain, with out any Englience and                                   |
|             | Lilling No Svelling now   |
|             | Other Exam-NL Cough Reflex &  |
|             | Herniel Lihi NL.  |
| (4)         | 1- 2 prochomet RIH  |
|             | ?' mild mujunto falled pain   |
|             | Halingering Tw Bobs   |
| p           | ) Come and Show When Frelling Leew  |
|             | - A   |
|             | d'i   |
|             |   |



ID# 226537

## PRISON HEALTH SERVICES, INOR PROPESSIONAL USE CALLY SICK CALL REQUEST CONFIDENTIAL RECORD

MOT TO BE PHOTO COPIED Print Name: Willie P. Strickland Date of Request: 8-23-05 Date of Birth:

Nature of problem or request: Pro-existing hervia - Injured myself oboying a direct order from DOC. In in a great deal of pain - This is my last affect to get the surgery before I pursue legal action Tree been hurting about 20 mos. To with 20st 1983,

|   |                 | Troklame 1   | XX6051                                  |
|---|-----------------|--|---|
|   | •               | Signature  |   |
| DO NOT WRITE BEL                            | OW THIS LINE    |  |   |
| ~~~   |                 | · · · · · · · · · · · · · · · · · · ·  |   |
| Date: 8 194 D                               |                 |  | /K                                      |
| Time: 2 1/5 AM PM                           | RECE            | IVED   | (7.7.                                   |
| Allergies: NKDH                             | Date: 8 241     | OŠ   | 0/25/03                                 |
| <i>a 1</i>                                  | Time: 11,45     |  | 810                                     |
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| (S)ubjective:                               | A D LA I        |  | 6                                       |
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| (O)bjective (V/S): T: 988 P:59              | R:              | BP: 1/2/174  | / wr.187                                |
|   |                 | - C/12   |   |
| W/mamb, to He ye steady &                   | 1047 - HID      | X4-40#   | an 8-4                                  |
| Tigo herria state when                      | he stop         | * Inus 4   | Recolo,                                 |
| but it about helpany more,                  |                 |  | is freel                                |
| (A)ssessment:                               | - TION          | a laster.  | - CX -XX                                |
|   | now, in         | 1-70-U   | 4 2,00                                  |
| altern Constant,                            | note: Pr        | f  |   |
| (P)lan: appt, with Mo. 71                   | 1 100           | 10 8/00  | S= S(N)                                 |
| Plan QQQL (2) It h My Zd                    | land, Ch        | VPO/XY   | 05-0600                                 |
| (1) min. (CFP) CO 20 CO 7 - 5 - 7 -         |                 | , , , , , ,  |   |
| * 1   |                 | The state of the s |   |
|   |                 |  |   |
| ( Refer to: MD) PA Mental Health Dental Dai | ily Treatment   | Return to Clinic   | PRN }                                   |
| CIRCLE O                                    | NE (            |  | J                                       |
| Check One: ROUTINE ( ) EMERGENCY (          | )               |  | - I - I - I - I - I - I - I - I - I - I |
| If Emergency was PHS supervisor notified:   | Yes ( ) No (    |  |   |
| / Was MD/PA on sall notified:               | Yes ( ) No (    | )  |   |
|   | 1               | $\bigcirc$   |   |
| lu Streklat I ) 00                          | •               | Va   |   |
| Wille                                       | Orn 1           | N)   | ····                                    |
| SIG   | NATUREANDI      | TITLE  |   |



## FOR PROPESSIONAL USE ONLY PRISON HEALTH SERVICES INCIDENTIAL RECORD SICK CALL REQUEST

MOT TO BE PROTO COPY

|       | Print Name: Willie Strickland Date of Request: 7-17-05 "                              |
|-------|---|
|       | ID # 226537 Date of Birth: Decation: 9-B 307  |
|       | Nature of problem or request: Kenew hottom rack profile                               |
|       | for preexisting condition "Hernia"  |
|       |   |
|       | Alien State   |
|       | Signature   |
|       | DO NOT WRITE BELOW THIS LINE  |
|       | Date: 7 / 18/ 85  |
|       | Date: 7 / 16 / 05 Time: / 720 AM PM  RECEIVED   |
|       | Allergies: NSDA Date: 7-18-05   |
|       | Time: 13.30   |
|       | Receiving Nurse Intials   |
|       | (Suprement Profile ) or and   |
| _     | (3) unjective.  |
| when  | Starsemy lee my Kenna Porsont, They moved mas   |
| 1091  | of our for Sat, and I have a problem setty refardown                                  |
| ,     | (0) bjective (V/S): T: 998 P: 80 R: 18 BP: 18/10 WT: #196                             |
|       |   |
| U     | IM and to Hey to steady gait - Alox4-   |
|       |   |
|       | (A)ssessment: Pollula for Misk for injury   |
|       |   |
|       |   |
|       | (P)lan: Refart HC y 7/21/05-affet, With Ms. Floyd, Chip                               |
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|       | (8.00Am) (2) BBPX4 daip.  |
| 1     |   |
| (     | Refer to: MDPA Mental Health Dental Daily Treatment (Return to Clinic PRN) CIRCLE ONE |
|       | Check One: ROUTINE () EMERGENCY ()  |
|       | If Emergency was PHS supervisor notified: Yes ( ) No ( )                              |
|       | Was MD/PA on call notified: Yes () No ()  |
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| , v   | SIGNATURE AND TITLE   |



#### INFIRMARY NURSING PROGRESS NOTES

| Date/Time       |   |          |                  |                |                    |         |
|-----------------|---|----------|------------------|----------------|--------------------|---------|
| 4-08-05         | 930 Annual st                             | esical   | Compl            | eted.          | TB A               | kir     |
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| INMATE NAME (LA | AST, FIRST, MIDDLE)                       |          | DOC#             | DOB            | R/S                | FAC     |
| Strick          | clard, Willie                             |          | 226537           |                | WIR                | VCF     |

PHS-MD-70049

Complete Both Sides Before Using Another Sheet



### FOR PROPESSIONAL USE ONLY PRISON HEALTH SERVOONINGENTIAL RECORD SICK CALL REQUEST NOT TO BE PHOTO COPIED

| Print Name: Willie Strickland Date of Request: 5-14-04   |
|--|
| ID# 2265-27 Date of Right: 2-0004  |
| ID# 2265-37 Date of Birth: Location: 3-Dorm  Nature of problem or request: Pain in right of Stornach beside  |
| Groins area  |
|  |
|  |
| Jobella Still  |
| Signature Signature  |
| DO NOT WRITE BELOW THIS LINE   |
| - 1 . d  |
| Date: 0 / 19/07 Time: 19/15 AM PM Allergies: 10/14  RECEIVED Date: 5-14-84 Time: 12.38 Receiving Nurse Intials   |
| (S)ubjective: I need some then done about my night side and abol pain,   |
| (O) bjective (V/S): T: 98 P: 78 R: 22 BP: 1/80 WT: 190  Lines IND swelling or rechers noted from and (A) ssessment:  |
| I limes I no swelling or rechers noted   |
| (A)ssessment:<br>Confut Sul all  |
| (P)lan: See On Rayapati  |
| 5-17-04 Dental Daily Treatment Return to Clinic PRN  |
| CIRCLE ONE   |
| Check One: ROUTINE () EMERGENCY ()   |
| If Emergency was PHS-supervisor notified: Yes () No () Was MD/PA on call notified: Yes () No ()  |
| - All In Ori   |
| ( V SIGNATURE AND TITLE  |
| ACCULATE AND A COUNTY AND A COU |

WHITE: INMATES MEDICAL FILE



## PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

| Print Name: Willie Strickland                                      | Date of Request: 5-5-04   |
|--|---|
| ID# 226537 Date  | of Birth: Location: 3-Oorn 79-T   |
| Nature of problem or request: Sedere                               | abdoninal pain on   |
| right side   |   |
| POR PROPESSIONAL USE ONL   | F   |
| CONFIDENTIAL RECOF   | 10 1/1/14 St. 12 = 26537  |
| NOT TO BE PHOTO COPIED   | Signature   |
| DO NOT WRIT  | E BELOW THIS LINE   |
| Date: 5 16 104   |   |
| Time: SO AM PM   | RECEIVED  |
| Allergies: NKQ   | Date: 5-6-04  |
|  | Time: 12,30   |
|  | Receiving Nurse Intials   |
| 14-11.   | in about aweel ago  |
| (3)  |   |
| but it keep getten   | mulerse.  |
|  | 1186  |
| (O) Finalism (VO) = 999  | 85 - 20 - 20/0 - 90   |
| (O)bjective (V/S): $\underline{T: 49}$ P: $\underline{V}$          | 86 R: 20 BP: 17 WT: 198   |
| na y treme fain when   | presence applied,   |
| Medled, Tenternos  | , keddrens touglose   |
| (A) ssessment:   | A State .   |
| are confide  |   |
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| (P) Jan: Refer to Bh. K  | Parapale Friday Um  |
| (P) Jan: Kefel 10 8 h  |   |
| 100m · 5-7-04  |   |
|  |   |
| Refer to: ( MD/PA Mental Health Denta                              | -   |
|  | CLE ONE   |
| Check One: ROUTINE () EMERGEN  If Emergency was PHS supervisor not |   |
| Was MD/PA on call not  |   |
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|  | TIMB 16-  |
|  | 1 comp to the contract of the |
| ( )  | SIGNATURE AND TITLE   |
| VIIITE: INMATECMENICAI EILE  |   |

WHITE: INMATES MEDICAL FILE



## PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

| Print Name: Wille Strickland   | Date of Request: 4-1-04  |
|--|--|
| ID # Date of Bir<br>Nature of problem or request: Flu. Sovie<br>Anklas   | th: 3 dorm   |
| FOR PROPESSIONAL USE O CONFIDENTIAL REC  | ORD Signature  |
|  |  |
| Date: 4 1 2 104 Time: 4 155 AM PM Allergies: DKDA  | RECEIVED  Date: 4-2-34  Time: 1.35  Receiving Nurse Intials 1.55 |
| (S)ubjective: I have chills, me<br>dore throat   | holy is aching ruling none,                                      |
| (O) bjective lot 190 th T 99.6 P<br>Lym about et orientel x3 Shu u<br>Reports caugh. lo general back                 | 92 R18 B/P 1/6 reason, dry, Karal Conquition wes                 |
| (A)ssessment:  |  |
| (P)lan: Com fo BID  Elidofied 36mg ti 10 BID  General Goong Fo BID  Sextend 500mg to 10 BID                          | k 5 day & Sastullal to source                                    |
| Refer to: MD/PA Mental Health Dental Dail  | •  |
| CIRCLE ON Check One: ROUTINE ( ) EMERGENCY ( ) If Emergency was PHS supervisor notified: Was MD/PA on call notified: | 10%  |
| 90   | Ukyku () 2   |
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## NAPHCARE NURSE'S NOTES

| DATE     | TIME        |  |           |
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|          |             | to HCLL ON 1/30 @ ago for MAN appt.    | Marichall |
| 3/23/04  | 1645        | Pranned Physical done - 7              | Bulling   |
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|          |             |  |           |
| 32304    | 1130        | White patch noted to Bonne cheek. Stat | L. Q      |
|          |             |  | dental    |
| 11/      |             | referral list. B. Like Por             | 2         |
| 424/05   |             | elamate summitted a register c/o h     | ernek     |
|          |             | Was seen by my of 2/22. Spe            | yce_      |
|          |             | c Mp on 424 in hel. to inmate          |           |
|          | ·           | Complaint + request for referral.      |           |
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## MEDICATION ADMINISTRATION RECORD

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| CHARTING FOR Physician                           | e's orders, medication notes, and in<br>Through  |   | The state of the s |
| Alt. Physician                                   |  | Telephone No.  Alt. Telephone   | M/Gcal Record No.  |
| Diagnosis Company                                | 111:11   | Rehabilitative<br>Potential   |  |
| Medicaid Number Medicare Number                  | Complete Entries Checked:  |   |  |
| PATIENT Star Moland                              | By:  | PATIENT CODE  22653   | Date:   ROOM NO   BED   FACILITY COL   |
| - Mariners V                                     | en   | 122653  | h 1/2  |

## MEDICATION ADMINISTRATION RECORD

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| Complete Entres Charles  |                          |  | read service and representation of the      |   |
| PATIENT CODE ROOM NO BED FACILITY CO   |                          | <i>1</i>                                     | and h                                       | A Zinni   |
|  | Strickland, Wil          | lie.   | PATIENT 1110                                | CODE ROOM NO BED FACILITY CO  |

## MEDICATION ADMINISTRATION RECORD

| STDT01<br>MEDICATIONS                                |                                |  |                                 |
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| UTILIZATION  | Y WANAGEN                   | MENT REFERRAL                           | REVIEW FORM   | ,  | 꼰           |
|--|-----------------------------|---|---|--|-------------|
| Please send this form  | with the Authorization      | ete and Legible. You must Typ           | e or Print<br>r at the time of the Appointment                    |  | RECEIVED    |
| Site Harne & Number  |                             |   | at the time of the Appointment                                    | E REE  | 皿           |
|  | Patient Name: ILa           | St. First.)                             |   |  | <u>~</u>    |
| VENTRESS-0845  | <i>I</i>                    |   | Dater (mm/dd/yy)  |  | 8           |
| Sife Phone #   | Streelar                    | nd Orllie                               | 2 125,05  | <u> </u>   | FEB         |
| 334-7758178  | Alias: (Last, First.)       |   | Date of Birth: "Imm/ddiyy)  |  |             |
|  | 1                           | j                                       |   |  | ∞<br>∞      |
| Site Fax #   | liunate #                   |   |   |  |             |
| 334-775-8173   | 001                         |   | PHS Custody Date: (mm/dd/   | 202  | 2005        |
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| Will there be a charge? Sex  | SS Number                   |   | Polantial Calana Dut . 1  |  |             |
| Tes   No   Project   |                             |   | Potential Rolesse Date (num                                       | ddyy)  |             |
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| Responsible party:   | Health Ties (Setules )      | Hedicard/Hedicald Horaged Care attents  |   |  |             |
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|  | · CLI                       | NICAL DATA                              | man a second  |  |             |
| Requesting Provider: A Mystani   | DIRP, PA DOOR               |   |   |  |             |
| A 7  | 4-                          |   | Settmenton with the control                                       |  |             |
| Facility Medical Director Signature and Date   | 1 malu                      | D. Milles Southfully                    | Isypantoans with Date of Oaset                                    | 11   |             |
| The second bill before Signature and Date.   | <i>J</i>                    | 1 1 11                                  | Pit & Istan   | - 11   |             |
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| COME NOTION DE X-100 D   | School and Marketon (SA)    | Results of a manufalua co               |   |  |             |
| Outpations Surgery (OS) Outputs (OA)   |                             | and were of a complaint off             | ected physical examination:                                       |  |             |
| ☐ Routine ☐ G  |                             | 1-10- Exa                               | menation.   | 11   |             |
|  | <u>पुराष</u>                |   | 9 1   | 11   |             |
| Estimated Date of Service (mm/dd/yy)   | , ,                         | Preveals No                             | Tru pocation  | <del>=</del> <u>- · · · · · · · · · · · · · · · · · · </u> | <u> </u>    |
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|  |                             | carries -                               | Trom the  | . ##   |             |
|  | оп Могару                   | Past.                                   |   | ·  |             |
| Number of Visits/Treatments: Creme   | <b>ऑस्त्रकृ</b>             | 1001                                    | -   | العاملية   | I ROSE ONLY |
| 12 000;  |                             |   | WAR PROP  | ESO DINL   |             |
| Specialist referred to:  | $\rightarrow$ 1             | Previous treatment and resp             |   |  |             |
| Type of Consultation, Treatment, Procedure of St   | - 1                         | NEOW Present                            | ses CONTID  | BENHOTO  | CORRECT     |
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| ou must include copies of portinent reports such   | as tab results.             |   |   |  |             |
| - alacimit constit teliotes  | with this form.             | seeFor security and enfety.             | , please do not inform patien                                     |  |             |
| Partitions Documents have been attacked and face   | a. 11                       | possible follow                         | i-n <b>h shbo</b> idpireutz <u></u><br>I Merze do licentouú baneu | E O I  |             |
| DECEMBER   |                             |   | whetherinitelity  | - 11   |             |
| Alterative Treatment Firm (explois here):  | Service Recommended and Aut | desiral                                 |   | <b></b>  |             |
| A series of the  | ' / -                       |   | 4 4   |  |             |
| Hore Information Requested: (See Attached)   |                             | ducas                                   |   | フル   |             |
| D. C. Carlotte   |                             | a - well                                | ・イーノノ   | ک معاور  |             |
| Residentified with requested information.  |                             |   |   | - 1 · 1 · 1  |             |
| onal Medical Directors   |                             |   |   | 11 %   | ;           |
| ed name and date required; Will Moster, MD   |                             | -                                       |   |  |             |
|  | <b>///</b>                  | <b>&gt;</b>                             |   | 11 1   |             |
| Do not write below the   | Mo, For Committee           |   | de la contra  | - T  |             |
| Mod Class  |                             | and Corporate Data Entry ONLY.          |   | <del>-</del> 1   | Λ.          |
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| Referral majorus   |                             |   | _, i .  | 11 1/2   | <b>√()</b>  |
| Referral review form 2-05-2004   |                             |   |   | <b>ゴ</b> / ハ   |             |
|  | •                           | •                                       | · · · · · · ·   |  | ; <b>U</b>  |

## Case 2:05-cv-00931-WKW-TFM Document 14-2 Filed 11/21/2005 Form n be Complete and Legible. You must Type or Print Please send this form with the Authorization Letter to the service provider at the time of the Appelatment

Page 40 of 45

PHS

|   |   | ecter to the service provider at the time of the Appointment  MOGRAPHICS        |            |
|---|---|---|------------|
| Site Name & Number:   | Patient Name: (Last,                                    |   |            |
| VENTRESS-0845   | Strickland  | 2 9 - 05  |            |
| Site Phone ≇  | Alias: (Last, First.)                                   | Date of Birth: (mm/dd/yy)   |            |
| 334-7758178   |   |   |            |
| Site Fax #  | Inmate #  | PHS Custody Date: (mm/dd/yy)  |            |
| 334-775-8178  |   | 537   |            |
| Will there be a charge? Sex ☐ Yes ☐ No ☐ Male ☐ Fe                                  | SS Number   | Potential Release Date: (mm/dd/yy)  |            |
|   |   |   |            |
| Responsible party: And ins.   | Health Ins. (Bickudes Me                                | edicare/Medicaid Managed Care alternative plans )  udes Medicare and Medicaid): |            |
|   |   | ICAL DATA   |            |
| Requesting Provider: Physider   | NP, PA Denta  |   |            |
| Facility Medical Director Signaure an   | Kayapati  | History of Mness/injury/sypmtoms with Date of Onset:                            |            |
|   |   | ] I Small Ki H- Will  |            |
| Service meets criteria for "approval yea proto                                      | Cay apati MiD   | No fignificant Sale<br>easily Reducible   |            |
| Place a check mark (*) in the Service and complete additional                       | ce Type requested (one only) applicable fields.         | easily Reducible  |            |
| Office Vest (OV) X-ray (OR)   | Scheduled Admission (SA)                                | Results of a complaint directed physical examination:                           |            |
| Outpatient Surgery (OS) Diatysis (DA  | <b>V</b>  | Flo- Examination  |            |
|   | Urgent .  | Reveals No Son frestin  |            |
| Estimated Date of Service (mm/dd/yy)  (This starts the approval window for the      | "Doen suffractivation period"                           | Ele- Examination. Reveals No Squifteetint Changes from the                      |            |
| Multiple Visits/Treatments:   | Radiation therapy                                       | fû31  |            |
| Number of Visits/Treatments:  | Chemotherapy  |   |            |
| Specialist referred to:   |   | Previous treatment and response (including medications):                        | 71         |
| Type of Consultation, Treatment, Proces   | dure of Surgery:  | TRUSPOR PROFESSIONAL  | INSE ONLY  |
| - HA Whigh  |   | CONFIDENTIAL  | RECORD     |
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| ou must include copies of pertinent rep<br>aray interpretations and specialty consu | orts such as lab results,<br>ilt reports with this form | ***For security and safety, please do not inform patient of                     |            |
| Portkient Documents have been atta  | ched and faxed.   | possible follow-up appointments***  | 11         |
| IM DETERMINATION:   | Offsite Service Recommended and                         | Authorized  | 11         |
| Alternative Treatment Plan (explain here):  |   |   | h          |
| ☐ More Information Requested: (See Attached)  | Date resubmitted:                                       |   | 8-0        |
| Resubmitted with requested information.   | - Aro i reactificati                                    |   | 18         |
| egional Medical Director Signature,<br>inted name and date required:                | 1   |   | 1          |
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| (Type:  | Med Class:  |   | \ \tau_{n} |
|   | area chass.   | UR Auth #:  | Ch         |

# Case 2:05-cv-00931-WKW-TFM Document 14-2 Filed 11/21/2005 UTILIZATION M. AGEMENT REFERRAL REVIE ORM Form must be Complete and Legible. You must Type or Print Please send this form with the Authorization Letter to the service provider at the time of the Appointment

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| Di   | EMOGRAPHICS  |
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| Site Name & Number: Patient Name: (Las   | t, First,) Date: (mm/dd/yy)  |
| Site Name & Number:  VENTRESS-0845  Site Phone #  334-7758-6840  Discreption of the phone #  Discreption of the ph | and withe 0614.04  |
| Site Phone # (Last First)  | Date of Blith: (mm/dd/yy)  |
| 334.775348   |  |
| A COLOR OF THE PROPERTY OF THE | PHS Custody Date: (mmlddyy)  |
| 2265   | 37 1012112   |
| SS Namber  | Potential Release Date: (mm/dd/ry)   |
| 334-7758ch   Instructio #  | 228109   |
| Responsible party: 12 Pts U Health Inc. (Extudes   | s Modikare/Modikaki Maragod Care alternative plans )<br>Belindes Modikare and Modikahiji:  |
|  | INICAL DATA  |
| Requesting Provider: Physician II NP, PA II Do   |  |
| Dr. Samuel Kay spate.  | History of Hunessimjury/sypontoms with Date of Onset   |
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| Facility Medical Director Signaure and Dates   | early reducable only vistable  |
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| Service meets criteria for "approvat via protocoli"  | ar long Standing and extry   |
| Place a check mark (v) in the Service Type requested (one only and complete additional applicable fields.  |  |
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| Number of Visits/Treatments: Core:   |  |
| Specialist referred to:  | Previous treatment and response (including medications):    LTM Joon LTrus LTM Let fragelied-  |
| Type of Consultation, Treatment, Procedure or Surgery:   | But is State he will be more   |
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| You must include copies of pertinent reports such as lab results, x-ray interpretations and specially consult reports with this form.  | **For security and safety, please do not inform patient of   |
| Pottest Dozmous have been attached and food.   | possible follow-up appointments***   |
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| UM DETERMINATION:  | I and Authorized   |
| Alternative Theatment Plan (explain here):   | ecable, coreservative Ry   |
| Et Nore Information Requested: (See Attached)  | eccente, consenuence 14 11   |
| Date resubmittee:  |  |
| Resubmitted with requested information.  | Flee in Brico  |
| Regional Medical Director Signature,   |  |
| winted name and date printed:  | D. 16 11   |
| Do not write below this line. For Care I   | Manager and Corporate Data Entry ONLY.   |
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| Trease send this form h   |                                   | ographics   | t the time of the Appointment             |       |
|---|-----------------------------------|---|---|-------|
| Site Name & Number:   | Patient Name: (Last, Fi           |   | Date: (mm/dd/yy)                          | -     |
| VENTRESS-0845   | STNEX lan                         | 2.  | 06,14,04                                  |       |
| Site Phone #  | Alias: (Last, First,)             |   | Date of Birth: (mm/dd/yy)                 | _     |
| 334-7758178   |                                   |   |   |       |
| Site Fax #  | Inmate #                          |   | PHS Custody Date: (mm/dd/yy)              | - I   |
| 334-775-8178  | 22653                             | 37  | 0121103                                   |       |
| Will there be a charge? Sex  ☐ Yes ☐ No ☐ Male ☐ Female                                   | SS Number                         |   | Potential Release Date: (mm/dd/yy)        |       |
| Responsible party: PHS  | Health Ins.(Excludes Med          | icare/Medicaid Managed Care altern<br>les Medicare and Medicaid): | ative plans )                             |       |
|   | CLINIC                            | CAL DATA  |   |       |
| Requesting Provider: Physician  | □ NP, PA □ Dental                 |   |   |       |
| Dr. Samuel Kay as   | orti.                             | History of illness/injur  | y/sypmtoms with <u>Date of Onset</u> :    |       |
| Facility Medical Director Signaure and Dat  | <del></del>                       | l exhib   | ago a Small RTH-<br>ducible only visible  |       |
|   | ration D                          | an One of   | Traling and establis                      |       |
| Service meets criteria for "approval via protocol"  |                                   | No. of the  | and I -                                   |       |
| Place a check mark (✓) in the Service Ty<br>and complete additional appl                  |                                   | reduced an  | anding and extrly fupinc for the diagnost | 1     |
| Office Visit (OV)   | Scheduled Admission (SA)          | Results of a complaint  | directed physical examination:            |       |
| Outpatient Surgery (OS) Dialysis (DA)   |                                   | Lonell R  | H - eatily reduce the                     | ı     |
| Routine   | Urgent                            | 1   | if H - earthy reduce ble                  |       |
|   |                                   | 1000-1ana   | 1-1-11-1                                  |       |
| Estimated Date of Service (mm/dd/yy)  |                                   | Cant ohla   | lahon of Rightingunal                     |       |
| (This starts the approval window for the "op  | en authorization period")         | Tring Ata B   | the Complications                         |       |
| Multiple Visits/Treatments:   | Radiation therapy<br>Chemotherapy | 1 11 - 1000   |   |       |
| Number of Visits/Treatments:  | Other:                            |   |   |       |
| Specialist referred to: Jurgary   |                                   | Previous treatment and Will Foone                                 | response (including medications):         |       |
| Type of Consultation, Treatment, Procedure  | or Surgery:                       |   | to he will be more                        |       |
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| Eval for Surgery of<br>RIH- Benyo and   |                                   |   |   |       |
| You must include copies of pertinent report x-ray interpretations and specialty consult r |                                   | ***For security and   | safety, please do not inform patient of   |       |
| Pertinent Documents have been attache   | SICNAL UME O                      | LY-   | follow-up appointments***                 |       |
| UM DETERMINATION:   | Offsite Service Recommended an    | od Authorized   | not !                                     | 20    |
|   | E PHOTO COPIE                     | D Retur   | well of                                   | 16.0% |
|   | Date resubmitted:                 | 1   | v (W                                      | 1     |
| Regional Medical Director Signature,<br>printed name and date required:                   |                                   | · · · · · · · · · · · · · · · · · · ·                             | ~   |       |
| prince name and usic required:  |                                   |   | / (men/ddyy)                              | 2     |
| Do not write  | below this line. For Case Ma      | inager and Corporate Data En                                      |   | 3     |
|   |                                   | <u></u>   | JR Auth #:                                | 7     |
| N 1940  | led Class:                        |   | ALEMAN .                                  |       |



#### PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: <u>Atrickland</u>, <u>Willie</u> BCDC#: <u>226537</u>

- 1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.
- 2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.
- I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.
- 4. I have had the opportunity to ask questions which have been answered to my satisfaction.
- 5. I understand there is no guarantee of success or permanence of the treatment.

FOR PROPESSIONAL USE ONLY
CONFIDENTIAL RECORD
NOT TO SE PHOTO COPIED

Patient's Signature

Date

Dentist's Signature

Date



#### PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

| Print Name: Willie Strickland  | Date of Reques                             | it: 12-2            | 20-04                    |
|--|--|---------------------|--------------------------|
| ID # 226537 Date of F<br>Nature of problem or request: Bad foot  | Right I                                    | ocation:            | HOVAL / KAR              |
| fixing   |  |                     |                          |
|  | Willie                                     | Stucke<br>Signature | 21                       |
| DO NOT WRITE B   |  |                     |                          |
| Date: 12/23/09 Time: 10,25 (AM)PM Allergies: NK/) H  | RECE Date: 12-20 Time: 215 Receiving Nurse | -01                 |                          |
| (S)ubjective: I need fillings  | put back.                                  | in my t             | eeth                     |
| (O)bjective (V/S): <u>T: P:</u>  | R:   | BP:                 | WT:                      |
| Jooth Partly broken  (A) ssessment:  | off on up                                  | per rigl            | t side                   |
| (A)ssessment:  | COMPLEA                                    | SOLOH ALAT CASS     | CORD                     |
| (P)lan: Wetch for nome in<br>destal appt   | n neusle                                   | ttenfa              | 2                        |
| Refer to: MD/PA Mental Health (Dental) D   | Paily Treatment                            | Return to Clin      |                          |
| Check One: ROUTINE (L) EMERGENCY  If Emergency was PHS supervisor notified  Was MD/PA on call notified | i: Yes ( ) No (                            | •                   |                          |
| R. M.  | homphini<br>GNATURE AND T                  | ODA.                | $\overline{\mathcal{M}}$ |
|  |  |                     |                          |

WHITE: INMATES MEDICAL FILE



**DEPARTMENT OF CORRECTIONS** 

DENTAL RECORD TREATME

| Date 1           | Tooth #                                | Diagnosis  | NOT TO SE PH   | 1 1 1 1  | · · |
|------------------|--|--|--|--|-----|
| Dațe             | 100011#                                | Diagnosis  | Treatment 100 / 10 | Initials   | CI  |
| 1/04             |  |  | 11/2 dental appaintment  | R.T.   |     |
| ·                |  |  |  |  |     |
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| 3-04             |  |  | dental Screening   | RI   |     |
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| رون<br>م         | 3,9                                    | Carred   | Vo amalgem # 3 OFL # 4 composite resin   | well   | L   |
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